For Washington State Nursing Home staff

From Residential Care Services, Aging and Disability Services
Department of Social & Health Services

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our mascot
Cousin IT

"This is I.T." Newsletter

Info and Tips from the MDS-WA Office—***Clinical*** *stuff,* ***Computer*** *stuff,* ***Reports*** *'n stuff, and other STUFF!*

By Marge Ray and Judy Bennett, State of WA, DSHS

Inside this issue:

Welcome to our new addition!

At 12:01 a.m. on October 1, 2010, MDS 3.0 arrived weighing up to 38 pages and almost 11 inches long by 7.5 inches wide. The labor was prolonged and there have been some post-delivery complications which seem to be correctable with time!

This new arrival has created quite a stir during its' first several weeks. The transition from MDS 2.0 to MDS 3.0, especially for residents on Medicare in September and October, was particularly stressful as each resident's situation had to be evaluated on a case-by-case basis to determine which option to use for the best Medicare payment.

Shortly after the implementation of 3.0, the new QIES ASAP data base hiccupped and could not process validation reports even though submission of assessments was still working. After several starts and stops, system repairs were made and on October 21, all assessments submitted from 10/1 through 10/21 were re-processed and validation reports were available.

Marge

Judy

Comings and Goings—Keeping track of the resident

A major change with MDS 3.0 involves how entry and discharge activities are completed. Gone is the one page tracking form for discharge and reentry; it is now replaced with two different item sets and new processes.

Entry tracking is now required for admissions as well as for resident returns to the facility after a discharge where return was anticipated. Entry tracking is a stand-alone process and cannot be combined with an assessment. The form is actually an 8-page item set that has resident identifying, administrative and demographic information. It is the first item set completed for all residents, including those on Medicare and Respite.

In order to code the Entry tracker as an admission (MDS item A1700 = 1) at least one of the following must be true:

- First time admission to this facility, **or**
- Has been in the facility previously, but discharged before the OBRA admission assessment was done, **or**
- Has been in the facility previously, but was discharged return not anticipated, **or**
- Has been in the facility previously but was discharged return anticipated, but did not return within 30 days of discharge

Continued on pg 2

Continued from pg 1—Keeping Track of the Resident

The Entry tracking record is coded a reentry (MDS item A1700 = 2) every time a resident is readmitted to the facility when they had previously been admitted and were discharged return anticipated. CMS considers a person to have been "admitted" when their OBRA admission assessment with CAAs was completed. Additionally, the resident must have returned within 30 days of the discharge.

Example: In completing the Entry Record, MDS item A0310-Type of Assessment, would be coded as follows:

- A0310A (OBRA reason for MDS) = 99
- A0310B (PPS reason for MDS) = 99
- A0310C (PPS OMRA reason) = 0
- A0310D (Swing Bed clinical change) = Blank (unless you are a swing bed)
- A0310E (Is this the first assessment since admit/reentry) = 0
- A0310F (Entry/Discharge Reporting) = 01
- Item A0410 (Submission Requirement) = 3**

****NOTE**: All assessments must use this code for Washington State

Complete the remaining applicable resident information (A0500 through A1550). A1600-Entry date would be the date of admission or the date of reentry. A1700-Type of entry is either an admission or reentry, based on the criteria that were described earlier. A1800 would record where the resident entered from and A2400 would be completed if there was a Medicare covered stay since 1/1/2010.

The next item to complete is X0100-Type of record which is coded as a 1-Add a new record. ****NOTE:** this item is coded as a 1 every time you complete an item set for first time submission to the data base. Then complete Z0400, signatures and dates of persons completing the Entry tracking item set.

Complete this tracking record within 7 days of admission/reentry and transmit to the data base within 10 days of the admission or entry. (Washington State has a more stringent rule for transmission than the federal requirements.) If the entry is an admission, then complete the MDS 2.0 assessment item set. If this is a reentry, an assessment may or may not be needed depending on the resident's condition, Medicare status or if an OBRA required assessment is due. The assessment process is a separate action and will be conducted and transmitted separately from the Entry Tracking process.

NH web sites in WA

Info for NH Professionals
http://www.aasa.dshs.wa.gov/professional/nh.htm

MDS Automation web page
http://www.adsa.dshs.wa.gov/Professional/MDS/Automation/

MDS Clinical web page
http://www.adsa.dshs.wa.gov/Professional/MDS/Clinical/

NH Rates web page
http://www.adsa.dshs.wa.gov/professional/rates/

NH Rates and Reports
http://www.adsa.dshs.wa.gov/professional/rates/reports/

Case Mix web page
http://www.adsa.dshs.wa.gov/professional/CaseMix/

Continued on pg 3

Laughter and tears are both responses to frustration and exhaustion...I myself prefer to laugh, since there is less cleaning up to do afterward.

Kurt Vonnegut, Jr.

Our goal... **Our goal is to help you accurately assess, code, and transmit the MDS. Accurate assessment forms a solid foundation for individualized care to help residents achieve their highest level of well-being.**

Continued from pg 2—Keeping Track of the Resident

Discharge Reporting is significantly changed with MDS 3.0. There are now 2 major categories: Discharge Assessments and Death in Facility tracking.

Death in facility tracking is a new process. When a resident expires in the nursing home or when they are out of the facility on a leave of absence (therapeutic or social leave or in the ER less than 24 hours but not admitted as an inpatient) and they expire, the death in facility tracking record is completed. The item set is the same one as used for Entry tracking. The A0310F item would be coded as a 12 in this situation and two additional items are completed (A2000-Discharge date and A2100-Discharge status). This tracker is to be completed within 7 days of the resident's death and transmitted within 10 days of that date (A2000 + 10 days). A discharge assessment is not completed when a resident expires, only the Death in facility record.

Discharge assessments will be completed for both discharge return anticipated and discharge return not anticipated. Administrative, demographic and clinical information is captured with the 27 page item set. Some key concepts for completing the discharge assessments:

- May be combined with an OBRA or PPS assessment when all the requirements for all assessments are met
- Date of discharge (A2000) must be the same as the assessment reference date (ARD) item A2300
- When the discharge is unplanned (i.e., resident has an emergent condition and goes to the hospital), complete what you can of the assessment and use dashes for the remaining items, including interview items

Discharge return not anticipated (A0310F=10) is selected when the resident discharges and the facility does not expect the resident to come back to the facility. Discharge return anticipated (A0310F=11) is selected when the resident is discharged but the facility expects a return within 30 days. If a resident for some reason does not return within 30 days, there is no requirement to do a modification to change the reason for assessment. The discharge assessment is to be completed within 14 days after the discharge date and transmitted within 10 days of the completion of the assessment.

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Electronic Maintenance of MDS 3.0 Assessments

With the implementation of MDS 3.0, CMS made some revisions to the State Operations Manual, Appendix PP which contains the Long Term Care regulations and guidance to surveyors. They clarified that facilities can maintain MDS assessments electronically even when the rest of the health record is not electronic. This means that facilities no longer need to print out a hard copy of the MDS 3.0 to put in the resident's clinical record. They must, however, provide access to or a copy of the MDS to anyone who has authority to access resident health records.

If the facility chooses to keep the MDS in an electronic format they will need to use electronic signatures or have a hard copy of the MDS 3.0 assessment signature pages for each MDS completed. There must be 15 months worth of these forms in the record if they choose this methodology.

Recommendations have been made to review the Washington State WAC related to having hard copies of MDS assessments in the clinical record. In the interim, surveyors have been instructed to focus on the accessibility of resident assessment information when needed, not on looking at whether or not a hard copy of the MDS is in the clinical record.

This change applies only to MDS 3.0 assessments. MDS 2.0 assessments will need to be maintained in hard copy format until they can be thinned from the record.

The MDS-WA newsletter publishes info that you can **really use** in your work with the MDS: tips and hints, new stuff from CMS, clinical info, technical help, notices about RUG reports, and more.
Sign up for the MDS-WA Listserv Newsletter by emailing LISTSERV@LISTSERV.WA.GOV In the subject line put:
SUBSCRIBE MDS-WA

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Q2IT Treasure Trove Tips

1) Question: If a resident has a lesion, must the lesion be "open" for it to be coded under M1040D? For example, a lesion could present as rough, lumpy or discolored intact skin.

Answer: Only code M1040D if the lesion is actually open.

2) Question: For Medicare Managed Care residents such as Group Health or Tri-Care, what code is chosen for type of assessment?

Answer: You may code A0310B (PPS assessments) with the corresponding PPS code. If you are doing a 14 day then choose the 14 day PPS code, if a 30 day, use the 30 day PPS code etc. Do not, however, choose the 07 Unscheduled PPS assessment code. You may also transmit them to the ASAP data base, but you are not required to do so. If the PPS assessment is also an OBRA assessment, you must transmit it.

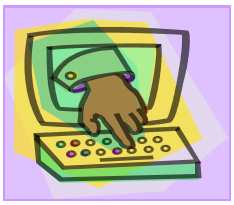
3) Question: If a resident is receiving therapy but is put on a therapy hold, does an End of Therapy (EOT) OMRA need to be completed?

Answer: Once the therapy hold is 3 days or longer, and the resident can be skilled for nursing care, you must complete the EOT OMRA. If and when the resident is able to participate again in therapy, a new evaluation and plan of treatment must be completed.

4) Question: The ADL CAA does not trigger for residents that are totally dependent and cognitively impaired does that mean we do not do it?

Answer: The triggering mechanism for the CAA process is different than the RAP process with MDS 2.0. The ADL CAA relates to functional performance and rehabilitation potential. It does not trigger when the resident is severely cognitively impaired because care planning for that resident will likely not be geared towards teaching skills to improve things like balance or increased independence with care because of the inability of the resident to follow through or carry over learning. A care plan is still needed but not geared so much toward rehabilitation but maintenance and prevention of decline. The CAA process is not required for those areas that were not triggered, but the facility may find it helpful for care planning to use the checklist in Appendix C as an adjunct to care planning.

Computer Corner



How to figure out what type of assessment is on the Validation Report

On the Final Validation Report, in the left column under Record #, is information about the type of assessment. Below is an example:

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A0310A: 01   A0310B: 01
A0310C: 0    A0310D: ^
A0310E: 1    A0310F: 99
Item Subset Code: NC
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The easiest way I have found is to have Page 1 of an assessment form handy and then look at the A0310 fields. In the example :

A031A:01 indicates an OBRA Admission Assessment.

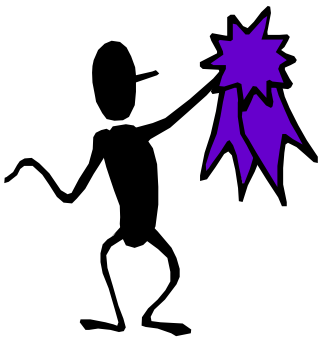
A0310B:01 indicates a PPS 5 day assessment

Item Subset Code: NC indicates the Comprehensive Assessment form was used

Item Subsets (from RAI Manual Chapter 2, pages 10-11):

NC – Nursing Home Comprehensive Item Set
ND – Nursing Home discharge Item Set
NO – Nursing Home OMRA Item Set
NOD – Nursing Home OBRA-Discharge Item Set
NP – Nursing Home PPS Item Set
NQ – Nursing Home Quarterly Item Set
NS – Nursing Home OMRA-Start of Therapy Item Set
NSD – Nursing Home OMRA-Start of Therapy and Discharge Item Set
NT – Nursing Home Tracking Item Set
XX—Inactivation Request Item Set

Judy Bennett, MDS Automation Coordinator



Thank you to everyone for all your hard work during the MDS 3.0 implementation.